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	155778	A. BUILDING _____ B. WING _____	01/07/2011

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WOODLAND MANOR NURSING CENTER	1212 E MAIN ATTICA, IN 47918

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F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 4, 5, 6, and 7, 2011 Facility number: 000323 Provider number: 155778 AIM number: 100288440 Survey Team: Cheryl Groth, RN, TC Megan Wyant, RN Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 4 Medicaid: 34 Other: 10 Total: 48 Sample: 12 Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 12, 2011 by Bev Faulkner, RN	F 000	RECEIVED JAN 28 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an	F 157	**F157 Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** Resident # 22's clinical record was reviewed to ensure that resident # 22 is voiding without symptoms of retention. Resident # 22's physician was given an update regarding resident urinary status,	

Approved 02031 Renewal

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a resident's physician was notified of a resident's change in physical condition related to the lack of urinary output for 1 of 12 residents reviewed for physician notification in a total sample of 12 residents. (Resident # 22) Findings include:	F 157	outputs, and progression of urinary status since the insertion of a Foley catheter. **Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what actions the facility took to correct the deficient practice for any client the facility identified as being affected.** 48 of 48 residents (100% of census) clinical records were reviewed by the DON or nurse designee to identify any resident with lack of physician notification regarding any condition which physician notification is warranted. Every identified resident with lack of physician notification was assessed by a licensed nurse and the physician was given an update regarding the situation, progress or lack of progress and the residents' current status. **Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur.**	

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F 157	Continued From page 2 The clinical record for Resident # 22 was reviewed on 1/5/11 at 10:50 A.M. Current diagnoses for the resident included, but were not limited to, urinary retention. A nurse's note, dated 12/2/10 at 6:00 P.M., indicated, "IV (intravenous) started in radial vein with 24 gauge needle....while securing IV site, resident flinched dislodging IV cath. Staff member started new IC in left basilic vein, collapsed. 3rd IV started in R (right) medial vein. IV patent, good blood return..." A nurse's note, dated 12/2/10 at 7:30 P.M., indicated, "...(no) output at this time. 1000 ml (milliliters) infused. D5 1/2 NC (dextrose in half normal saline) started (at) 75 ml/hour...." A nurse's note, dated 12/2/10 at 9:30 P.M., indicated, "...(no) urinary output at this time..." A nurse's note, dated 12/3/10 at 2:00 A.M., indicated, "...IV of D5 1/2 NS running (at) 75 cc/hr (hour)...has (not) voided thus far this shift..." A nurse's note, dated 12/3/10 at 5:00 A.M., indicated, "...resident has (not) voided thus far this noc (night)..." There was no documentation in the nursing notes to indicate the physician was notified of the lack of urinary output for the resident on 12/3/10. A nurse's note, dated 12/4/10 at 3:00 P.M., indicated, "Resident has not voided-bladder distended et (and) firm to touch-call to (name of physician)...N.O. (new order)...Foley (a catheter)..."	F 157	On 01/24/11 an in-service regarding physician notification was conducted for all licensed nurses. The content included when the physician should be notified and examples of what condition, situation would warrant physician notification. Review of the physician notification Policy and Procedures was conducted by the DON and nurse management staff- the policy was determined to be sufficient. **Describe how the corrective actions will be monitored to ensure the deficient practice will not recur.** The DON/designated nurse manager will be responsible for monitoring compliance to ensure this deficient practice does not recur. The method for monitoring will include a weekly audit of medical records to ensure physician notification is accomplished for all warranted situations/conditions. The audit will be conducted on the following schedule: for 2 weeks 100% of records will be reviewed, for 4 weeks 50% of records will be	

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F 157	Continued From page 3 Review of the "Comprehensive Intake-Output Record" indicated the resident voided one time during the evening of 12/2/10, two times on the day and evening shift of 12/3/10, and one time during the night on 12/4/10. The record indicated the resident did not have any urine output during the night shift on 12/3/10. During an interview with the MDS Coordinator, on 1/6/11 at 3:40 P.M., she indicated the intake and output record was started after the IV was started on 12/2/10. She indicated there was no documentation to indicate the resident voided during the night shift on 12/3/10. She indicated the intake and output record did provide evidence that the resident only had an absence of urinary output during the night shift on 12/3/10. She further indicated the night shift nurse should have notified the physician related to the lack of urinary output for the resident during the night shift on 12/3/10. A current facility policy, provided by the MDS Coordinator on 1/5/11 at 2:20 P.M., titled "Physician Notification" indicated, "...Each resident's medical care will be ordered and supervised by the resident's attending physician...Using professional judgment to compile date in a timely manner, nurse will inform the physician by telephone as soon as possible of signs or symptoms of acute need included, but not limited to...change in status of condition...or other symptoms of immediate need...."	F 157	audited and then for 4 weeks 25% of records will audited. Results of the audits shall be reported to the IDT/QA committee on a bi-weekly basis at the end of this audit period if compliance has not been met evident by 100% of records found with no incidents of lack of physician notification then the IDT/QA committee can determine the weekly audits can be stopped. Records will then be reviewed on an as needed basis by the DON/designated nurse manager to continue on-going monitoring. The DON will report to the IDT/QA committee on a quarterly basis the results of these audits. The QA/IDT committee will determine if the high frequency audit schedule needs to be restarted based on results of audits. The QA/IDT committee will indicate restart of the high frequency audits if 2 or more occurrence of lack of physician notification occur over a 30-day time period.	
F 252 SS=C	3.1-5(a)(2) 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252	**All corrections in-services, audits, systemic changes will in place by February 6, 2011.**	

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F 252	Continued From page 4 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the grout along the shower wall was free of substances, failed to ensure the baseboard along the wall under the sink in the bathroom located in the shower room was in good repair, and failed to ensure a wall in the bathroom in the shower room was free from chipped paint. This deficient practice affected 1 of 1 communal shower rooms and 1 of 1 communal bathrooms located in the shower room, and this deficient practice had the potential to affect 48 of 48 residents who utilized the facility shower room. Findings include: During the environmental tour on 1/6/11 at 10:05 a.m., with the Maintenance Supervisor and Housekeeping Supervisor the following was observed: 1. In the corner of the communal shower room, where the floor meets the wall, there was a 3 inch area of a black and brown substance present on the tile. During an interview with the Housekeeping Supervisor at the time of the observation, she indicated the area could be easily cleaned and should not have been present on the tile. 2. In the communal bathroom located in the	F 252	**F252 Corrective actions** 1. Communal shower room was thoroughly cleaned by housekeeping staff on January 6, 2011. 2. Communal bathroom was painted by maintenance supervisor on January 6, 2011. 3. Baseboard in communal bathroom was replaced by maintenance supervisor on January 6, 2011. **Identification of same deficient practice.** HFA, housekeeping supervisor and maintenance supervisor shall complete rounds throughout facility to ensure there are no other areas identified. If other areas identified they shall be cleaned, repaired or replaced, **Systemic changes** The maintenance and housekeeping supervisors shall monitor the areas in communal shower room and bathroom and do monthly checks.	

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F 252	Continued From page 5 communal shower room there was a three foot section of wall at eye level that had chipped paint. During an interview with the Maintenance Supervisor at the time of the observation, he indicated there should not have been any chipping paint on the wall. 3. In the communal bathroom located in the communal shower room there was a three foot section under the hand washing sink where the wall meets the floor that was missing the tile baseboard. During an interview with the Maintenance Supervisor at the time of the observation, he indicated the tile was old and matching tile could not be located. During an interview with the Maintenance Supervisor at the completion of the environmental tour on 1/6/11 at 11:15 a.m., he indicated he understood the concerns. During an interview with the Administrator on 1/6/11 at 11:20 a.m., she indicated she understood the concerns related to the environmental tour. 3.1-19(f)(5)	F 252	**Monitoring** The maintenance and housekeeping supervisor shall report to the QA committee at the next scheduled meeting. **Completion of repair** The QA committee shall determine if further repair/cleaning needed based on report by maintenance/housekeeping supervisor. **Completion date** All corrections and repairs shall be made by February 6, 2011.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	**F279 Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** Resident # 9's care plan was updated to reflect the use of a pressure pad alarm to the bed and wheelchair. The Care Plan for the resident was also updated to	

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F 279	Continued From page 6 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care plans were updated related to a fall intervention, a wanderguard having been discontinued by the physician, and a medication having been discontinued by the physician. This deficient practice affected 2 of 12 residents reviewed for updated careplans in a sample of 12 residents. (Resident #9 and #22). Findings include: 1.a. Resident #9's record was reviewed on 1/5/11 at 3:50 p.m. Diagnoses for Resident #9 include history of falls, right hip fracture repair, and Alzheimer's dementia. A physician's order, dated 10/14/10, indicated Resident #9 had an order for a pressure pad alarm to the bed and wheel chair at all times. A care plan, dated 10/21/10, indicated the	F 279	include the discontinuance of the Wander Guard. Resident # 22's care plan was updated to reflect the discontinuance of the coumodin/risk for bleeding care plan. **Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what actions the facility took to correct the deficient practice for any client the facility identified as being affected.** 100% of the resident care plans were reviewed by the MDS coordinator or nurse designee to identify any care plan in need of updates to reflect the resident's current status. All care plans were updated as warranted. **Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur.** On 01/26/11 the DON conducted an educational session with the	

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F 279	Continued From page 7 resident was a "...fall risk...." Documentation was lacking to indicate the care plan had been updated to reflect the pressure pad alarm to the bed and wheel chair. 1.b. A physician's order, dated 12/10/10, indicated the resident's wanderguard was to be discontinued. A care plan, dated 10/21/10, indicated the resident was at risk for elopement r/t "...cognitive loss inability to understand limitations...interventions...code alert door (wanderguard) on at all times, check placement every shift, check weekly to ensure proper function...." Documentation was lacking to indicate the care plan had been updated to reflect the wanderguard had been discontinued. During an interview with the Director of Nursing on 1/6/11 at 4:10 p.m., she indicated Resident #9's care plans should have been updated related to the pressure pad alarm and the discontinuance of the wanderguard. 2. The clinical record for Resident # 22 was reviewed on 1/5/11 at 10:50 A.M. Diagnoses for the resident included, but were not limited to, congestive heart failure, hypertension, and chronic renal disease. A physician's order, dated 12/11/10, indicated, "...DC (discontinue) Coumadin (a blood thinner)..." A current care plan for the resident, initially dated 8/10/10 and last updated 11/1/10, indicated the resident was on Coumadin and at risk for bleeding. The care plan was not discontinued at	F 279	MDS coordinator to include information regarding care plan updates. A form was developed for the MDS coordinator to use to track resident changes that would warrant an update to the care plan. The MDS coordinator will review the new physician orders obtained from the previous day or days. The physician orders shall be reviewed each day the MDS coordinator is working. The physician orders will provide initial information for the MDS coordinator that will indicate the potential for a care plan update need. **Describe how the corrective actions will be monitored to ensure the deficient practice will not recur.** The DON/designated nurse manager will be responsible for monitoring compliance to ensure this deficient practice does no recur. The method for monitoring the care plans will be as follows: the care plans shall be audited on a weekly basis to ensure updated completed. The frequency of the care plan audits will be 50% of the	

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F 279	Continued From page 8 the time the Coumadin was discontinued on 12/11/10. An interview with the MDS Coordinator on 1/7/11 at 8:40 A.M., indicated the care plan for the Coumadin was not discontinued and should have been when the resident was no longer taking the medication. 3.1-35(a) 3.1-35 (b)(1)	F 279	care plans for 2 weeks and then 25% of the care plans per week for 4 weeks. The audit results will be documented on the tracking device initiated and the results of the audits will be reported to the IDT/QA committee on a bi-weekly basis. At the end of the audit period if no errors or lack of care plan updates are noted then the IDT/QA committee can determine the weekly audits can cease. However, if the audits reveal that care plan updates were needed then the QA committee will determine the high frequency audits start until 100% compliance achieved. Care plans will then be updated by the MDS/Care Plan coordinator. On a quarterly basis the MDS/Care Plan coordinator will report care plan updates to the QA committee. **All corrective actions in service, audits and systemic changes will be in place by February 6, 2011.**	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident's were free of medication error rates greater than 5 %. This was evidenced by 4 medication errors out of 45 opportunities for error which resulted in a medication error rate of 8.88%. This directly affected 3 of 12 residents observed during medication pass. (Resident's # 4, # 27, and # 6) (Qualified Medication Aides # 1 and # 2) Findings include: 1. During medication pass observation for Resident # 4 with Qualified Medication Aide (QMA) # 2, on 1/5/11 at 8:15 A.M., the following was observed: QMA # 2 administered Cilostazol (an antiplatelet	F 332		

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F 332	Continued From page 9 medication) 50 milligrams to Resident # 4. A pharmacy label on the medication indicated the medicine was to be taken on an empty stomach. An interview with QMA # 2 at the time of the observation indicated the resident had recently eaten breakfast. She indicated the medication was scheduled to be given at 8:00 A.M., but the time may need to be changed if the medication should be taken on an empty stomach. The clinical record for Resident # 4 was reviewed on 1/7/11 at 2:55 P.M. Review of the physician's order summary for 1/11 indicated the resident had a current physician's order for Cilostazol 50 milligrams twice daily. The summary indicated the medication was scheduled for 8:00 A.M. and 4:00 P.M. 2. During medication pass observation for Resident # 27 with Qualified Medication Aide (QMA) # 1, on 1/5/11 at 8:30 A.M., the following was observed: QMA # 1 prepared the resident's medications. QMA # 1 placed Lisinopril (a medication used to treat high blood pressure) 5 milligrams and Metoprolol (a medication used to treat high blood pressure) 25 milligrams in a medication cup. Both of the physician's orders for these medications indicated the medicine should be held if the resident's systolic blood pressure was lower than 100/60. QMA # 1 entered the resident's room and handed the medication cup directly to the resident and told her these were her morning medications. At that time, QMA # 1 was questioned regarding the need to take a blood pressure measurement prior to the	F 332	**F332 Describe what the facility did to correct the deficient practice for each client cited in the deficiency.** Resident # 4 Medication Administration record was reviewed. The physician of resident # 4 was contacted and a request for medication time change was made so that Cilostazol is scheduled to be given prior to breakfast. Resident # 27's blood pressure was immediately measured to ensure the resident not hypotensive. Resident # 27's physician was updated on resident # 27's recent blood pressure and hold parameters with no changes. QMA #1 was counseled regarding the necessity of taking preliminary vitals as ordered by physician so that the medication can be held if necessary. Resident # 6 was assessed and noted to have no adventisious lung sounds. Resident # 6's physician was updated regarding resident's respiratory status. QMA #1 was	

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F 332	Continued From page 10 administration of the blood pressure medications. QMA # 1 indicated she was supposed to take the resident's blood pressure prior to administration, and at that time, she left the room and obtained a blood pressure cuff and took the resident's blood pressure. An interview with QMA # 1 immediately following the above observation indicated she was supposed to take the resident's blood pressure because their were orders to hold the medications if her blood pressure was low. She indicated she always takes the resident's blood pressure. The clinical record for Resident # 27 was reviewed on 1/6/11 at 2:50 P.M. Review of the physician's order summary for 1/11 indicated the resident had the following current physician's orders: Lisinopril 5 milligrams hold if the systolic blood pressure was less than 100/60 Metoprolol 25 milligrams hold if the systolic blood pressure was less than 100/60 3. During medication pass observation for Resident # 6 with Qualified Medication Aide (QMA) # 1, on 1/6/11 at 8:20 A.M., the following was observed: QMA # 1 prepared the resident's medications. A pharmacy label on the resident's Spiriva inhaler (a medication used to dilate the airways) indicated the resident was to take 2 puffs per capsule. QMA # 1 then entered the resident's room and administered the resident's Spiriva inhaler. The resident inhaled 1 time from the inhaler.	F 332	counseled regarding necessity of ensuring that hand held inhalers are administered as prescribed. **Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what actions the facility took to correct the deficient practice for any client the facility identified as being affected.** Medication Administration records were reviewed and medications that were prescribed to be administered prior to meals were confirmed to be administered during a time frame that is prior to meals. Times were changed as needed. The medication administration records were reviewed to ensure that preliminary assessments such as vitals were completed and documented as per the physician order and the facility policy. **Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur.**	

F332
On 01/24/11, 01/25/11 an in-service was completed for all medication aides and nurses. The content of the in-service included information regarding medication administration, vital signs, parameters as related to med administration, metered dose inhalers and general medication pass guidelines. QMA # 1 and QMA # 2 were provided an educational session regarding administering meds as prescribed and completing all preliminary assessment as related to medication administration.

Describe how the corrective actions will be monitored to ensure the deficient practice will not recur.

Observations of medications administration will be conducted to ensure that medications are being administered as directed and that preliminary assessments such as vitals are being accomplished with 100% accuracy. These observations will be conducted by the DON and or designated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155778	A. BUILDING _____ B. WING _____	01/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND MANOR NURSING CENTER	1212 E MAIN ATTICA, IN 47918

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 11 An interview with QMA # 1 immediately following the above observation indicated the resident only inhaled 1 time from the inhaler. The clinical record for Resident # 6 was reviewed on 1/7/100 at 2:53 P.M. Review of the physician's order summary for 1/11 indicated the resident had a current physician's order for Spiriva 18 micrograms, inhale the contents of 1 capsule by mouth via the hand inhaler once a day. 4. A current facility policy, provided by the Assistant Director of Nursing on 1/5/11 at 1:50 P.M., titled "Oral and Sublingual Medication Administration" indicated, "...Oral and sublingual medication will be administered using safe and proven med pass methods following all applicable general medication administration guidelines...check medication name, strength, route and dosage interval on the prescription label, on the MAR (medication administration record) and on the individual unit-dose package...obtain vital signs as indicated for certain drugs..."	F 332	licensed nurse at a rate of 10% of census two times per week for 4 weeks and then 10% of census 1 time per week for an additional 4 weeks. The observations will be documented on a medication pass observation form. The DON shall report to the IDT/QA committee on a bi-weekly basis the results of the observation. At the end of the direct observation time frame the IDT/QA committee can recommend completion of the observations if a rate of 0% errors accomplished over a 4-week period. However, if errors during observation observed the QA/IDT committee shall recommend the observation start at the high rate of 10% twice per week and continue until a 0% rate achieved over a 4 week time frame. **All systemic changes will be implemented by February 6, 2011.**	
F 372 SS=F	3.1-48(c)(1) 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 372		

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F 372	Continued From page 12 failed to ensure the dumpster had a closable lid and failed to ensure the area around the dumpster was not littered with refuse. This deficient practice affected 1 of 1 dumpsters located behind the facility. This deficient practice had the potential to affect 48 of 48 residents who resided in the facility. Findings include: During the environmental tour on 1/6/11 at 10:05 a.m., with the Maintenance Supervisor and Housekeeping Supervisor the following was observed: There was a dumpster located outside behind the facility. There were no lids located on the dumpster and the trash was heaping out over the top of the dumpster. There were 3 recliner chairs and 4 wood palates located outside of the dumpster. There was a wet blanket and wash rag on the ground outside of the back door. There was paper and plastic litter scattered on the ground in the area surrounding the dumpster. During an interview with the Maintenance Supervisor at the time of the observation, he indicated the dumpster caught on fire a few weeks prior and the lids melted. He indicated the recliners and palates could not be placed in the dumpster so they were there awaiting pick up from the trash company. He indicated the facility replaced the recliner chairs last week. He indicated he would usually rake up the debris around the dumpster but had not done it recently due to the snow and cool temperatures. He indicated the area around the dumpster should not have been so littered. The Maintenance Supervisor indicated he understood the concern.	F 372	**F372 Corrective actions** Recliners, wood palates, blanket, washcloth and litter were removed on January 6, 2011. The lids for the dumpster have been ordered and received. Will be installed by February 6, 2011. **Identification of same deficient practice.** All staff shall be in serviced on January 26, 2011 on proper disposal of items and trash and to ensure lids on dumpster are closed. **Systemic changes** The maintenance supervisor and HFA shall monitor the area and maintenance supervisor to do monthly maintenance checks. **Monitoring** The maintenance supervisor shall report to the QA Committee at the next scheduled meeting.	

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F 372	Continued From page 13 During an interview with the Administrator on 1/6/11 at 11:20 a.m., she indicated the trash company assured her the lids for the dumpster had been ordered and should be in place in the next week. She indicated the lids melted during a fire in the dumpster on 12/20/10. She indicated the litter on the ground around the dumpster was from the cats and squirrels getting into the dumpster looking for food. She indicated she understood the concern. 3.1-21(i)(5)	F 372	**Completion of repair** The QA committee shall determine if further monitoring needed based on report by maintenance supervisor. **Completion date** All corrections shall be completed by February 6, 2011.	